| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15C0001073 | A. BUILDING 00<br>B. WING | 07/27/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| RIVERPOINTE SURGERY CENTER | 500 ARCADE AVE STE 100<br>ELKHART, IN46514 |

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| S0000 | The visit was for a licensure survey.<br><br>Facility Number: 009967<br><br>Survey Date: 07-25-11 to 07-27-11<br><br>Surveyors:<br>Brian Montgomery, RN<br>Public Health Nurse Surveyor<br><br>Linda Plummer, RN<br>Public Health Nurse Surveyor<br><br>Karilyn Tretter, RN<br>Public Health Nurse Surveyor<br><br>QA: claughlin 08/15/11 | S0000 | | |
| S0132 | 410 IAC 15-2.4-1 (b)(8)<br><br>The governing body shall do the following:<br><br>(8) Ensure surgical procedures are performed only by a physician, dentist, or podiatrist who is privileged to perform such procedures according to medical staff bylaws, regulations, and/or policies and procedures. | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | Based upon document review and interview, the governing body failed to ensure that surgical procedures at the center were only performed by physicians privileged by the governing body for 1 of 9 physicians at the center.<br><br>Findings:<br><br>1. Review of the medical credential file for physician #9 indicated that the last reappointment had occurred on 10-23-2007 for two years and the surgical privileges expired 10-31-2009.<br><br>2. On 07-27-2011 at 1215 hours, employee #A6 was requested to provide a list of surgical cases performed by physician #9 in 2011. Review of the requested information indicated that 20 surgical cases were performed in 2011.<br><br>3. On 07-27-11 at 1300 hours, employee #A1 confirmed that physician #9 was in the process of being recredentialled. | S0132 | 1. Plan offi Correctton<br>The physician was grantted ttemporary privileges on Augustt16, 2011<br>The dattes offi reappointtmentt and otther key dattes offi license expiratton and DEA expiratton will be enttered intto a ttracking calendarA reportt will be reviewed every montth ffior any ittems due tto expire witthin30 days so tthatt tthe updatte can be obttained and processed prior tto expiratton.<br>Exhibitt(s)<br>Temporary privileges approval letter<br>Calendar example witth expiratton dattes<br>2. Preventton:<br>Monittoring offi tthe use offi tthe calendar ttracking soffiware and periodic auditt offi credenttaling ffiorms<br><br>3. Responsible partty:<br>Executtve Assisttantt<br><br>4. Correctton Completted<br><br>a. Temporary privileges grantted on Augustt16, 2011<br>b. Presentted tto Board ffior reappointtmentt att Board meettng on Septtember1, 2011 | 08/16/2011 |

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| S0162 | 410 IAC 15-2.4-1 (c)(5) (G)<br><br>Require that the chief executive officer develop and implement policies and programs for the following:<br><br>(G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who provide direct patient care.<br><br>Based on personnel file review and job descriptions, the facility failed to ensure CPR competence according to facility policy for 4 of 6 (P1, P3, P4, P5) ASC employees.<br><br>Findings include:<br>1. During personnel file review on 7/26/2011, there was no documentation that P1 (a pre-op/post-op RN) was competent in PALS (Pediatric Advanced Life Support). Job description for Perioperative Registered Nurse includes "Minimal knowledge, skills, and abilities required: 1. Current CPR Certification. ACLS and PALS Certification."<br>2. During personnel file review on 7/26/2011, there was no documentation that P3 (a sterilization tech) was competent in CPR (Cardiopulmonary Resuscitation). Job description for Sterilization Tech (Surgery Assistant) includes "Maintains all required certifications (CPR)."<br>3. During personnel file review on 7/26/2011, there was no documentation that P4 (a pre-op/post-op RN) was competent in ACLS (Advance Cardiac Life Support). Job | S0162 | 1. Plan offi Correctton<br>Job descripttons were changed tto allow tthe RNs tto obttain PALS and ACLS witthin6 montths offi hire<br>A check listt was esttablished tto conffirm tthatt all clinical sttaffiving directt pattentt car,ewhetther conttract,tagency personnel, or employed by tthe surgery centter have currentt CPR competency<br>Exhibitt(s)<br>Job descriptton offi RN<br>Listt tto ttrack matterials tto have in ffile<br>2. Preventton: Check listt ffior employee ffile tto include veriffication offi CPR prior tto datte offi ffirstt assignmentt offi directt pattentt care.<br><br>3. Responsible Partty<br>Executtve Assisttantt<br><br>4. Correctton<br>Completted Augustt26, 2011 | 08/26/2011 |

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| | description for Perioperative Registered Nurse includes "Minimal knowledge, skills, and abilities required: 1. Current CPR Certification. ACLS and PALS Certification."<br>4. During personnel file review on 7/26/2011, there was no documentation that P5 (a pre-op/post-op RN) was competent in BLS (Basic Life Support), ACLS, or PALS. Job description for Perioperative Registered Nurse includes "Minimal knowledge, skills, and abilities required: 1. Current CPR Certification. ACLS and PALS Certification." | | | |
| S0166 | 410 IAC 15-2.4-1 (c)(5) (l)<br><br>Require that the chief executive officer develop and implement policies and programs for the following:<br><br>(l) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.<br>Based upon document review and interview, the facility failed to ensure the review of all policies/procedures was performed triennially and failed to ensure a policy/procedure for verifying illegible information in the patient record.<br><br>Findings: | S0166 | 1. Plan offi Correctton<br><br>Policy written tto review policies and procedures annually tto assure updattes tto regulattons and sttandards are completted and sttaffi is educatted Policy written tto address whatt sttaffi is tto do iffi writtng on medical record is nott legible<br>Exhibitt(s)<br>Policy tto review and updatte policies and procedures annually | 08/26/2011 |

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| | 1. Review of the facility policies/procedures manuals failed to indicate a review had been performed by the administrator or another responsible party in the last three years.<br><br>2. On 07-26-2011 at 0825 hours, employee #A6 confirmed that the facility had failed to review all of its policies/procedures during the last three years and that the facility lacked a policy/procedure requiring a triennial review of all policies/procedures by an individual or a committee.<br><br>3. The policy/procedure Medical Records and Documentation (revised 04-11) failed to indicate a process for verifying information with questionable legibility in the MR.<br>4. On 07-26-2011 at 1500 hours, employee #A6 confirmed the facility lacked a policy/procedure for verifying illegible information in the patient record. | | Policy offi whatt sttaffi is tto do tto veriffiy inffiormatton when illegible tto tthe reader<br>2. Preventton:<br>An annual calendar offi whatt mustt be presentted tto tthe governing body will be esttablished and marked offi when completted tto assure policies are reviewed, updatted as needed and presentted tto tthe governing body ffior approval.<br><br>3. Responsible Person(s): Executtve Assisttantt<br><br>4. Correctton Completted<br><br>a. Policies written by Augustt26, 2011<br>b. Presentted ffior approval att Governing Body meettng Septtember 1, 2011 | |

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| S0212 | 410 IAC 15-2.4-1(d)(2)(A & B)<br><br>(d) In accordance with center policy, the governing body shall do the following:<br><br>(2) Ensure the following:<br><br>(A) The center develops, implements, and maintains written medical staff policies and procedures for emergencies, initial treatment, and transfer.<br><br>(B) The center provides immediate lifesaving measures within the scope of service available, to all persons in the center, to include, but not be limited to, the following:<br><br>(i) Timely assessment.<br>(ii) Basic life support.<br>(iii) Proper transfer mode.<br>Based on policy and procedure review, patient medical record review and staff interview, the governing board failed to ensure that staff implemented the facility transfer policy for 3 of 5 transfer patients (N1, N3, and N14).<br><br>Findings:<br>1. at 4:40 PM on 7/25/11, review of the policy and procedure "Transfers, Hospital" with a policy number of CT-01 and a last revision date of 04/05, indicated:<br>a. under "Procedure:", it read: "Emergency Transfers:...3. One copy of | S0212 | 1. Plan offi Correctton<br>Sttaffi will use a pattentt ttransffier log tthatt will include tthe name offi tthe pattentț reason ffior ttransffier discharge summary obttained, ttransffier record in medical recorȡ and tthe datte tthe ttransffier is sentt ffior peer review.<br><br>The ttransffier ffiorm will now include a ttextt box tto remind tthe person complettng tthe ffiorm tthatt tthe original sttays in tthe medical record and a copy is routted tto QIC Coordinattor<br>Exhibitt(s)<br>Transffier log<br>Transffier ffiorm | 08/26/2011 |

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| | the chart is made for the hospital. Transfer form will be completed and a copy will be retained for the Clinical Director..."<br><br>2. review of patient medical records through out the survey process of 7/25/11 to 7/27/11 indicated:<br>a. patients N1, N3 and N14 were transfer patients who were lacking a transfer form in their medical records<br><br>3. interview with staff member ND at 11:00 AM on 7/27/11 indicated:<br>a. transfer forms should have been completed for patients N1, N3 and N14, per facility policy | | 2. Preventton: A montthly auditt tto compare ttransffier records received witth clinical log and complicatton reportts received will be conductted tto assure QIC receives tthe ttransffier record, tthe clinical log is correcttly sttattng tthe discharge sttattus, and tthe complicatton reportts are correctt<br><br>3. Responsible Person(s): QIC Coordinattor<br><br>4. Correctton Completted<br><br>a. Policy written by Augustt 26, 2011<br>b. Presentted tto governing body ffior approval on Septtember 1, 2011 | |
| S0230 | 410 IAC 15-2.4-1(e)(5)<br><br>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:<br><br>(5) Provide for a periodic review of the center and its operation by a utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility. | | | |

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| | Based upon document review and interview, the governing board failed to ensure a periodic review of the center was performed by a committee composed of a minimum of 3 physicians who do not have a financial interest in the facility.<br>Findings:<br>1. The RiverPointe Surgery Center Board of Managers bylaws (last approved 7-2010) indicated the following: [The Board shall] Provide for a periodic review of The Center and its operation by a Utilization Review Committee composed of a minimum of three licensed physicians who have evidenced their lack of financial interest in The Center.<br>2. The RiverPointe Surgery Center Medical Staff Bylaws (last reviewed/approved 07-28-2010) indicated the following; The Medical Quality Improvement Committee (MQIC) shall conduct ... utilization review studies, as necessary, designed to evaluate the appropriateness of surgery and use of the Center services...[and]...A quorum of the MQIC shall be the Medical Director or his designee and two other members.<br>3. The Medical Quality Improvement Program (revised 04-05) failed to indicate | S0230 | 1. Plan of Correction: Three physicians who are non-investors in the surgery center will be appointed to serve on a utilization review committee.The Medical Staff Bylaws will be reviewed and clarified if needed to address the responsibilities for peer review.Exhibit(s)Appointment of three physicians2. Prevention: Review of utilization review activities will be conducted and presented quarterly to the Governing Body 3. Responsible Person(s): Executive Assistant 4. Correction Completed: a. Bylaws will be reviewed by August 31, 2011b. Potential members for Utilization Review Committee membership will be contacted before August 26, 2011c. Membership and committee responsibilities will be presented to governing body at September 1, 2011 meeting | 08/31/2011 |

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| | that Utilization Review will be conducted by at least 3 licensed physicians who do not have a financial interest in The Center.<br>4. During an interview on 07-26-2011 at 1013 hours, employee #A1 indicated that only two licensed physicians (MD #10, MD# 11) attended the MQIC meetings and did not have a financial interest in the facility. | | | |
| S0310 | 410 IAC 15-2.4-2(a)(1)<br><br>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:<br><br>(1) All services, including services furnished by a contractor.<br>Based on document review and interview, the facility failed to monitor one direct service (radiology) and 7 contracted services (bioengineering, biohazardous waste, housekeeping, laboratory, laundry, maintenance, and medical transcription) through its Quality Improvement program.<br><br>Findings:<br><br>1. The policy/procedure Medical Quality Improvement Program (revised 04-05) indicated the following: There shall exist | S0310 | 1. Plan offi Correctton<br>The QIC Coordinattor has developed a systtem tto gatther inffiormatton and reportt on services ffiurnished by outtside conttracttors. The inffiormatton will be reportted tto tthe Governing Body witth actton, as needed, tto adjustt service delivery or conttracttors. The Governing Body will be presentted tthe evaluatton and reporttng ffiorm att tthe Septtembter board meettng.<br>Exhibitt(s)<br>Evaluatton and reporttng ffiorms<br>Policy | 08/26/2011 |

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| | at the Center an organized program to improve the quality of care and promote more effective and efficient utilization of facilities and services.<br><br>2. Review of the Medical Quality Improvement, Risk Management, and Peer Review Committee minutes for 2010 and 2011 failed to indicate documentation of periodic monitoring and reporting for the direct service of radiology and the 7 contracted services of bioengineering, biohazardous waste, housekeeping, laboratory, laundry, maintenance, and medical transcription for the facility.<br><br>3. During an interview on 07-26-2011 at 1630 hours, employees #A4 and #A6 confirmed the facility was not monitoring the services indicated above. | | 2. Preventton: The QIC coordinattor will review tthe service delivery offi outtside conttracttors and consulttantts and reportt ffindings tto tthe Board<br><br>3. Responsible Person(s): QIC Coordinattor, Executtve Assisttantt<br><br>4. Correctton Completted<br><br>a. Policy and ffiorms developed by Augustt26, 2011<br>b. Presentted tto governing body ffior approval att meettng offi Septtember1, 2011 | |

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| S0334 | 410 IAC 15-2.4-2.2(a)(2)<br><br>(2) A process for reporting to the department each reportable event listed in subdivision (1) that is determined by the center's quality assessment and improvement program to have occurred within the center.<br>(b) Subject to subsection (e), the process for determining the occurrence of the reportable events listed in subsection (a)(1) by the center's quality assessment and improvement program shall be designed by the center to accurately determine the occurrence of any of the reportable events listed in subsection (a)(1) within the center in a timely manner.<br>(c) Subject to subsection (e), the process for reporting the occurrence of a reportable event listed in subsection (a)(1) shall comply with the following:<br>(1) The report shall:<br>(A) be made to the department;<br>(B) be submitted not later than fifteen (15) working days after the reportable event is determined to have occurred by the center's quality assessment and improvement program;<br>(C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and (D) identify the reportable event, the quarter of occurrence, and the center, but shall not include any identifying information for any:<br>(i) patient;<br>(ii) individual licensed under IC 25; or<br>(iii) center employee involved;<br>or any other information.<br>(2) A potential reportable event may be identified by a center that:<br>(A) receives a patient as a transfer; or<br>(b) admits a patient subsequent to discharge; from another health care facility subject to a reportable event requirement. In the event | | | |

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| | that a center identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying center shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program.<br>(3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures.<br>(4) A quality assessment and improvement program may refrain from making a determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law.<br>(d) The center's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each center. The department's public report will be issued annually.<br>(e) Any serious reportable listed in subsection (a)(1) that:<br>(1) is determined to have occurred within the center between:<br>(A) January 1, 2009; and<br>(B) the effective date of this rule; and<br>(2) has not been previously reported;<br>must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-2.4-2.2) | | | |
| | Based on policy and procedure review, incident/event report review and staff interview, the facility failed to ensure that a policy related to reportable events | S0334 | 1. Plan of Correction: A policy will be developed and staff educated about the adverse events and the reporting of events. The Medical Director will | 08/26/2011 |

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| | 15C0001073 | A. BUILDING 00<br>B. WING | 07/27/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| RIVERPOINTE SURGERY CENTER | 500 ARCADE AVE STE 100<br>ELKHART, IN46514 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| | existed.<br><br>Findings:<br>1. at 12:30 PM on 7/26/11, review of facility incident reports indicated:<br>a. a pt. wrong site surgery had been documented on an event/incident report in May 2010<br>b. the facility did not report this to the State as per the reportable events rule<br><br>2. review of policies and procedures through out the survey process of 7/25/11 to 7/27/11 indicated:<br>a. the facility did not have a policy related to adverse events that are reportable to the State<br><br>3. interview at 12:30 PM on 7/26/11 with staff members NB and ND indicated:<br>a. it was unknown that there was a list of reportable adverse events in the state rules that are required to be reported to the State | | also educate the medical staff via written and verbal communication of the responsibility to assess an occurrence. The policy will include the process for review by the quality assessment and improvement program and reporting to the state as required by regulations.Exhibit(s)Policy on reporting events2. Prevention: Employees and medical staff will receive education in September and annually about reporting requirements. 3. Responsible Person(s): QIC Coordinator 4. Correction Completed: a. Policy will be written by August 26, 2011b. Policy presented to Governing Body for approval on September 1, 2011 | |

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| S0606 | 410 IAC 15-2.5-3(b)(1)<br><br>(b) The organization of the medical record service must be appropriate to the scope and complexity of the services provided as follows:<br><br>(1) The services must be directed by a registered record administrator (RRA) or an accredited record technician (ART). If a full-time and/or part-time RRA or ART is not employed, then a consultant RRA or ART must be provided to assist the qualified person in charge. Documentation of the findings and recommendations of the consultant must be maintained.<br>Based upon document review and interview, the facility lacked a qualified medical records (MR) director for their MR department.<br><br>Findings:<br><br>1. On 07-25-2011 at 1130 hours, employee #A2 was requested to provide documentation including a personnel file for the Registered Health Information Technician (RHIT) or Registered Health Information Administrator (RHIA) qualified director of medical records and none was provided prior to exit.<br><br>2. On 07-26-2011 at 1340 hours, employee #A6 was requested to provide a policy/procedure or job description | S0606 | 1. Plan offi Correctton<br>An agreementt witth a consulttantt RHIT/RHIA was signed Augustt23, 2011<br>Exhibitt(s)<br>Agreementt witth RHIT/RHIA<br>Policy regarding an agreementt witth an RHIT/RHIA<br>Tracking and evaluattng outtside service agreementts RHIT/RHIA included.<br>2. Preventton: An agreementt witth an RHIT/RHIA will be conttnued, renewed, and monittored<br><br>3. Responsible Person(s): Executtve Assisttantt<br><br>4. Correctton Completted | 08/26/2011 |

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| | indicating that the MR department was directed by RHIT or RHIA professional and none was provided prior to exit.<br><br>3. On 07-27-2011 at 1100 hours, employee #A3 indicated that an agreement with a consultant RHIT/RHIA providing medical records oversight had expired in 2007 and the facility failed to have an agreement with a qualified professional at the present time. | | a. Agreementt completted Augustt 23, 2011<br>b. Process offi ttracking offi agreementt and evaluatton progress completted by Augustt26, 2011<br>c. Board approval offi agreementt and outtside service conttractt evaluatton systtem att Septtembet1, 2011 | |
| S0624 | 410 IAC 15-2.5-3(c)(7)<br><br>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:<br><br>(7) The center shall ensure the confidentiality of patient records. The center must develop, implement, and maintain the following:<br><br>(A) A procedure for releasing information or copies of records only to authorized individuals, in accordance with federal and state laws.<br><br>(B) A procedure that ensures that unauthorized individuals cannot gain access to patient records.<br>Based upon document review, observation and interview, the facility failed to ensure that medical records (MR) were not accessible to unauthorized individuals. | S0624 | 1. Plan offi Correctton Policies on tthe prottectton offi medical records have been written and implementted The cleaning sttaffi will have access tto tthe medical record areas only when tthatt area is sttaffi or | 08/26/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | Findings:<br>1. Review of the policy/procedure Medical Records, Protected Health Information, Need to Know (revised 04-05) failed to indicate how the facility provided physical barriers to limit access to MR by unauthorized individuals at the facility.<br>2. During a facility tour of medical records storage on 07-25-2011 at 1430 hours, accompanied by employees #A2 and #A6, large rolling file stacks without lockable covers or barriers to prevent unauthorized access to protected health information were observed in the administrative offices at the facility.<br>3. During a facility tour of medical records storage on 07-25-2011 at 1430 hours, accompanied by employees #A2 and #A6, five cardboard MR storage boxes containing patient records awaiting transport to an archive service were observed in the area adjacent to the rolling file stacks.<br>4. During an interview on 07-25-2011 at 1430 hours, employee #A6 indicated that the contracted housekeeping services cleaned the areas where MR were stored in the evening when other facility staff | | only when tthe ffile area is conttained tto preventt accessAny ttemporary sttorage offi records awaittng digittal sttorage will be locked and boxes clearly marked tto notte tthatt tthe records are nott AP or AR ffiles and require access prottectton<br><br>Exhibitt(s)<br>Policy on prottectton offi records<br><br>2. Preventton: Sttaffi will be educatted on limitted access tto tthe medical record area The cleaning sttaffi access will be resttrictted and monittored The ffile sttorage area will be reviewed ffior abilitty tto lock racks tto preventt access.<br><br>3. Responsible Person(s): Business Office Manager<br><br>4. Correctton Completted<br><br>a. Complette resttrictted access tto area by cleaning sttaffi by August 26, 2011<br>b. Presentt policies and procedures approval tto governing body on Septtember1, 2011<br>c. Complette assessmentt offi abilitty tto lock rolling ffile area by Septtember9, 2011 | |

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| | were not present. | | | |
| S0772 | 410 IAC 15-2.5-4(b)(3)(M)<br><br>These bylaws and rules must be as follows:<br><br>(3) Include, at a minimum, the following:<br><br>(M) A requirement that a medical history and physical examination be performed as follows:<br><br>(i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed.<br><br>(ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff.<br><br>(iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy.<br>Based on medical staff rules and regulations review, patient medical record review and staff interview, the facility failed to ensure that history and physical examinations were either performed or updated on the day of surgery for 7 of 14 | S0772 | 1. Plan offi Correctton<br>Medical sttaffi members were sentt infffiormatton aboutt tthe requirementt offi a histtory and physical tto be perffiormed on tthe day offi tthe procedure or no greatter ttha30 days prior tto tthe procedure. An updatte mustt be perffiormed on tthe | 07/28/2011 |

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| | patients. (N1, N4, N7, N10, N11, N12 and N13)<br><br>Findings:<br>1. at 4:40 PM on 7/25/11, review of the medical staff rules and regulations indicated:<br>a. on page 5, in item d., it read: "A pre-operative medical evaluation and physical examination must be performed and recorded or dictated by an anesthesiologist or surgeon on all patients receiving treatment in the operating rooms immediately before surgery and made part of the medical record."<br><br>2. review of patient medical records through out the survey process of 7/25/11 to 7/27/11, indicated:<br>a. pt. N1 had a history and physical performed 6/20/11 and surgery on 6/22/11 with no updated noted documented on the history and physical on the day of surgery<br>b. pt. N4 had a history and physical performed on 11/24/10 and surgery on 11/29/10 with with no updated noted documented on the history and physical on the day of surgery<br>c. pt. N7 had:<br>A. a physician office history and physical dated 8/4/10<br>B. a surgery date of 9/8/10<br>C. a brief history and physical form (form # RSC - 300) that was not | | datte offi tthe procedure, a histtory and physical greatter ttha30 days old cannott be updatted, a new one mustt be completted<br><br>Forms were revised tto ttrigger appropriatte completton offi histtory and physical inffiormatton<br>Sttaffi were educatted tto acknowledge ttheir role in sttopping movementt offi tthe pattentt ffirom tthe operattve area intto tthe operattng rooms unttl a histtory and physical is in tthe medical record<br><br>Exhibitt(s)<br>Medical record ffiorms<br>Memo tto medical sttaffi members regarding requirementts ffior a histtory and physical<br><br>2. Preventton:<br>Histtory and physical will be checked by tthe circulattng nurse prior tto tthe pattentt moving intto tthe operattng room.<br><br>3. Responsible Person(s): OIC Coordinattor<br><br>4. Correctton Completted<br><br>a. Sttaffi educatton completted July 28, 2011<br>b. Medical record ffiorms re-design completted Augustt 12, 2011<br>c. To be presentted tto governing | |

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| | complete and had no date documented<br>d. pt. N10 had:<br>A. surgery on 5/11/11<br>B. a dictated history and physical with a dictation date of 6/8/11<br>C. a brief History and Physical form (form # RSC - 300) that is not complete<br>e. pt. N11 had:<br>A. Surgery on 9/30/10<br>B. a progress note from the physician's office dated 9/21/10 that serves as a history and physical<br>C. was lacking an update to the 9/21/10 note on the day of surgery<br>f. pt. N12 had:<br>A. surgery on 6/22/10<br>B. a letter dated 6/17/10 to the attending/referring physician of the proposed surgery<br>C. no history and physical in the patient chart<br>g. pt. N13 had:<br>A. surgery on 4/29/11<br>B. a letter dated 4/19/11 to the attending/referring physician related to the proposed surgery<br>C. no history and physical in the patient chart<br><br>3. interview with staff member ND at 10:00 AM on 7/27/11 indicated:<br>a. this staff member was unaware of the medical staff rules and regulations<br>b. it was unknown that history and | | body on Septtember1, 2011 | |

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| | physical examinations needed an update on the day of surgery<br>c. pts. N12 and N13 have letters to physicians that the surgeon was utilizing as a history and physical, but was not per standards of practice for a history and physical<br>d. pts. N7 and N10 had brief history and physical forms, but the forms were not complete | | | |
| S0780 | 410 IAC 15-2.5-4(b)(3)(N)<br><br>These bylaws and rules must be as follows:<br><br>(3) Include, at a minimum, the following:<br><br>(N) A requirement that all practitioner orders are in writing or acceptable computerized form and must be authenticated by a responsible practitioner as allowed by medical staff policies and within the time frames specified by the medical staff and center policy not to exceed thirty (30) days.<br><br>Based on policy and procedure review, medical staff rules and regulations review, patient medical record review, and staff interview, the facility failed to ensure that 2 of 5 transfer patients had an order for transfer (N5 and N14).<br><br>Findings:<br>1. at 4:40 PM on 7/25/11, review of the policy and procedure "Transfers, | S0780 | The policy on tthe ttransffier offi pattentts was amended tto include a requirementt ffior a ttransffier order by a physician.<br>The medical sttaffi rules and regulattons will be reviewed and changed as appropriatte<br>Nursing sttaffi and physicians will receive educatton.<br>A ttransffier checklistt will be developed. | 08/26/2011 |

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| | Hospital" with a policy number of CT-01 and a last revision date of 04/05, indicated:<br>a. the policy does not address obtaining an order to transfer the patient<br><br>2. at 4:40 PM on 7/25/11, review of the medical staff rules and regulations indicated:<br>a. in "Section 2. Orders", there is nothing related to patient transfers and the need for a physician order for transfer<br><br>3. review of patient medical records through out the survey process of 7/25/11 to 7/27/11 indicated:<br>a. patients N5 and N14 were transfer patients who were lacking a physician order for transfer<br><br>4. interview with staff member ND at 11:00 AM on 7/27/11 indicated:<br>a. all transfer patients are to have an order for transfer<br>b. neither the medical staff rules and regulations, nor the transfer policy addresses the need for a practitioner order for transfer of a patient | | Exhibitt(s)<br>Transffier policy changed<br>Transffier ffiorm changed<br><br>1. Preventton: Sttaffi will complette a ttransffier ffiorm and presentt copy tto tthe QIC coordinattor who will review ttracking mechanism and assure orders are in tthe record<br><br>2. Responsible Person(s): QIC Coordinattor<br><br>3. Correctton Completted<br><br>a. Transffier policy and ffiorm changes draffied by August26<br>b. Evaluatton offi changes tto medical sttaffi rules and regulattons completted by August26<br>c. Presenttatton tto governing body on Septtember1, 2011 | |

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| S0840 | 410 IAC 15-2.5-4(c)(2)<br><br>(c) The anesthesia service is responsible for all anesthesia administered in the center as follows:<br><br>(2) A requirement that anesthesia equipment must be checked for operational readiness and safety prior to patient administration. Documentation to that effect shall be included in the patient's medical record.<br><br>Based upon document review and interview, the facility failed to ensure that anesthesia equipment was checked prior to use on patients in 2 of 12 examples.<br>Findings:<br>1. On 07-25-2011 at 1130 hours, employee #A2 was requested to provide a policy/procedure requiring all anesthesia equipment be checked for safety and operational readiness prior to use on patients and none was provided prior to exit.<br>2. During a review of 12 medical records, 2 records (N3 and N12) were observed to lack documentation of anesthesia equipment checks in the designated location on the anesthesia record.<br>3. During an interview on 07-26-2011 at 1630, employee #A4 confirmed the facility failed to have a policy/procedure | S0840 | 1. Plan offi Correctton<br>Policy and procedure was written requiring tthe anestthesia equipmentt be checked prior tto each procedure The locatton offi tthis inffiormatton was on tthe anestthesia ffiorm and anestthesia sttaffi was reminded offi tthe requirementt tto conductt tthe check and documentt itt on tthe ffiorm<br><br>Exhibitt(s)<br>Policy on anestthesia equipmentt checks<br>Currentt anestthesia ffiorm<br><br>2. Preventton:<br>Anestthesia equipmentt checks will be conffirmed by tthe anestthesia sttaffi and documentted The medical record will be auditted tto assure documenttatton offi tthe check occurs.<br><br>3. Responsible Person(s): QIC Coordinattor<br><br>4. Correctton | 08/26/2011 |

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| | requiring anesthesia equipment checks prior to use on patients. | | Completted<br><br>a. Policy offi tthe checking offi tthe anestthesia equipmentt written by Augustt26, 2011<br>b. Policy presentted tto Governing body att Septtembe1, 2011 meettng | |
| S0900 | 410 IAC 15-2.5-5(a)<br><br>(a) All patient care services must meet the needs of the patient, within the scope of the service offered, in accordance with acceptable standards of practice. Patient care services must be under the direction of a qualified person or persons. Patient care services must require the following:<br>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to implement its policy related to the assessment of pain on admission to the facility, for 14 of 14 patient records (N1 through N14).<br><br>Findings:<br>1. at 12:05 PM on 7/25/11, review of the policy and procedure "Pain Assessment and Management", with a policy number "CP - 03", indicated:<br>a. under "Policy", it read: "Patients will be assessed initially and periodically to accomplish the goal of effective pain management..."<br>b. under "Guidelines", it reads: "1. Document the patient pain assessment on the preoperative history and upon | S0900 | 1. Plan offi Correctton<br>The pre-operattve nursing care record will be revised tto add a pain assessmentt and managementt documenttatton sectton<br><br>Exhibitt(s)<br>Form<br><br>2. Preventton:<br>Nursing sttaffi will be educatted on tthe assessmentt and managementt offi pain and tthe recording offi tthis assessmentt and managementt in tthe medical record. The medical records will be auditted tto review compliance and sttaffi rreducatted as needed tto achieve ttottal compliance<br><br>3. Responsible Person(s): QIC coordinattor | 08/26/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15C0001073 | A. BUILDING 00<br>B. WING | 07/27/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| RIVERPOINTE SURGERY CENTER | 500 ARCADE AVE STE 100<br>ELKHART, IN46514 |

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| | admission to RiverPointe Surgery Center..."<br><br>2. review of patient medical records through out the survey process of 7/25/11 to 7/27/11, indicated:<br>a. pts. N1 through N14 were lacking documentation of a pain assessment on admission to the facility as required per policy<br><br>3. interview at 5:10 PM on 7/25/11 with staff member ND indicated:<br>a. this staff member was unaware that the pain policy required a pain assessment on admission<br>b. it was assumed that this documentation would be placed on the "Admission Record" form (form # RSC - 103), but upon review of the form, it was found there is no area for pain documentation<br>c. nursing staff have not been assessing pain level on admission to the facility as policy dictates | | 4. Correctton Completted<br><br>a. Pre-operattve nursing care ffiorm revised by August 26, 2011<br>b. Sttaffi educatted by August 26, 2011<br>c. Form and correcttve actton presentted tto tthe Governing Body on Septtember1, 2011 | |

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| S1040 | 410 IAc 15-2.5-6(3)(F)<br><br>Pharmaceutical service must have the following:<br><br>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:<br><br>(F) Instructions to the patient on the use of take home medication is the responsibility of the prescribing practitioner.<br><br>Based upon document review and interview, the facility failed to have a policy/procedure regarding the physician responsibility of instructing the patient (when indicated) on the use of take home medication.<br>Findings:<br>1. On 07-25-2011 at 1130 hours, employee #A2 was requested to provide a policy/procedure regarding dispensing medications to patients while at the facility and none was provided prior to exit.<br>2. The Pharmacy consultant report dated 03-18-2011 indicated the following under the category Samples; Samples stocked for Dr. Boling. These are brought from his office. Patients are not charged for these and are sent home with the patient. | S1040 | 1. Plan offi Correctton<br>Sending samples offi medicattons home witth pattentts was sttopped affier tthe pharmacy consulttantt broughtt itt tto tthe attentton offi tthe sttaffi lastt MarchA policy was written tto conffirm tthatt no medicattons are dispensed and no samples are given tto pattentts by tthe ffiacilitty<br><br>Exhibitt(s)<br>Policy<br><br>2. Preventton: Sttaffi was educatted on tthis issue in May 2011. Sttaffi will review tthe newly written policy tthatt conffirms tthatt tthere will be no dispensing offi medicatton by tthe ffiacilitty<br><br>3. Responsible Person(s): QIC Coordinattor<br><br>4. Correctton | 09/09/2011 |

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| | Also samples stocked for Dr. Meyer (Ciprodex). These samples are used in surgery and remainder is sent home with patient. Patients are not charged for these.<br>3. On 07-27-2011 at 1215, employee #A6 confirmed the facility failed to have a policy/procedure for the physician responsibility of instructing the patient (when indicated) on the use of take home medication. | | Completted<br><br>a. Policy written by Augustt26<br>b. Policy presentted tto Governing Body ffior approval att Septtember1r 2011 meettng<br>c. Sttaffi educatted on newly written and approved policy by Septtember9, 2011 | |
| S1182 | 410 IAC 15-2.5-7(c)(2)<br><br>(c) A safety management program must include, but not be limited to, the following:<br><br>(2) An ongoing center-wide process to evaluate and collect information about hazards and safety practices to be reviewed by the committee.<br>Based upon document review and interview, the facility failed to document an ongoing, center-wide program which collected and evaluated information about hazards and safety practices.<br><br>Findings:<br><br>1. The RiverPointe Surgery Center Medical Staff Bylaws (last reviewed/approved 07-28-2010) indicated the following; The Medical Quality | S1182 | 1. Plan offi Correctton<br>A saffietty survey policy and ffiorm was developed. A saffietty survey will be completted att leastt once a quartter The resultts offi tthe survey will be presentted tto tthe MQIC committee att itts quartterly meettng and a summary will be presentted tto tthe Governing Body att itts quartterly meettng<br><br>Exhibitt(s)<br>Saffietty survey policy<br>Saffietty survey ffiorm | 08/26/2011 |

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| | Improvement Committee (MQIC) shall also incorporate the functions of a Safety Committee. These functions shall include, but not be limited to: ...(9)(a) ...procedures for identifying workplace hazards, including scheduled periodic inspections and reviewing the results of such inspections ...[and] ...(10). ensuring that records of scheduled and periodic inspections to identify unsafe conditions and practices are kept for three years. These records must identify the persons conducting the inspection, the unsafe conditions and work practices that have been identified, and the action taken to correct these unsafe conditions and work practices.<br><br>2. Review of the MQIC meeting minutes for 2010 and 2011 failed to indicate a report by the Safety Committee for 6 of 6 meetings, failed to document any recommendations (if indicated) regarding review of Incident Reports (Quality Monitor Report) for 6 of 6 meetings, and failed to document any discussion or review of periodic scheduled facility safety inspections conducted by a member or members of the Safety Committee for 6 of 6 meetings.<br><br>3. On 07-26-2011 at 1203 hours, employee #A1 was requested to provide records of periodic facility safety | | 2. Preventton: A saffietty survey will be conductted quartterly A listt offi ittems tto be completted quartterly will be mainttained and reviewed ffior completteness<br><br>3. Responsible Person(s): Executtve Assisttantt<br><br>4. Correctton Completted<br><br>a. Policy and ffiorm were developed by Augustt19, 2011<br>b. Saffietty survey will be completted by Augustt26, 2011<br>c. Governing body will be presentted witth survey resultts att Septtember1, 2011 meettng | |

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| | inspections performed by the Safety Committee and none was provided prior to exit.<br><br>4. On 07-26-2011 at 1600, employee #A6 confirmed that the MQIC committee was not reviewing facility safety inspections to identify, evaluate, and remediate environmental safety issues and problems for the facility. | | | |
| S1198 | 410 IAC 15-2.5-7(c)(6)<br><br>(c) A safety management program must include, but not be limited to, the following:<br><br>(6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies.<br>Based upon document review and interview, the facility failed to establish an Emergency and Disaster Preparedness plan in cooperation with local, state, and federal agencies.<br>Findings:<br>1. On 07-25-2011 at 1130 hours, employee #A2 was requested to provide documentation indicating coordination of services with area, state, and federal disaster agencies and none was provided prior to exit.<br>2. Review of the existing Disaster Plan | S1198 | 1. Plan offi Correctton<br>The ffiacilitty will prepare a comprehensive emergency managementt and disastter preparedness plan tto deffine itts acttvittes during an emergency and a disastter The ffiacilitty conttactted tthe local healtth departtmentt emergency planning departtmentt tto inquire aboutt alerttng tthe departtmentt tto tthe surgery centter's emergency managementt and disastter preparedness acttvittes and received a reply tthatt coordinatton acttvittes and planning were under review by tthe countty healtth departtmentt and tthe ffiacilitty would be conttactted latter | 09/09/2011 |

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| | documents failed to indicate any relationship or attempts to coordinate a response with the facility landlord and 40% shareholder Elkhart General Hospital.<br>3. During an interview on 07-27-2011 at 1015 hours, employee #A6 confirmed the facility was not currently associated with any local, regional (District 2), state, or federal disaster agencies. | | Exhibitt(s)<br>Elkhartt Countty Healtth Departtmentt communicatton<br><br>2. Preventton: The ffiacilitty will educatte itts sttaffi and provide inffiormatton tto tthe countty aboutt itts acttvittes when an emergency or disastter occurs The plan will be reviewed periodically and any changes submitted tto tthe countty healtth departtmentTThe ffiacilitty will practtce itts response tto emergencies and disastters as appropriatte tto itts planned acttvittes ffior responding<br><br>3. Responsible Person(s): QIC Coordinattor<br><br>4. Correctton Completted<br><br>a. A comprehensive emergency managementt and disastter preparedness plan will be completted and presentted tto tthe governing body att tthe Septtembe1r, 2011 meettng.<br>b. Once approved by tthe governing body, tthe plan will be presentted tto tthe Elkhartt Countty Healtth Departtmentt by Septtembe2r, 2011<br>c. The ffiacilitty sttaffi will be educatted on emergency and disastter response. Quartterly drills will be conductted on att leastt response tto a | |

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| S1210 | 410 IAC 15-2.5-8(c)(1)<br><br>(c) All centers shall comply with all regulations set forth in this rule and with 410 IAC 5, when radiology services are provided on-site by the center, including, but not limited to the following:<br><br>(1) Radiology services must be supervised by a radiologist or radiation oncologist.<br>Based upon document review and interview, the facility failed to ensure its radiology services were supervised by a radiologist or radiation oncologist.<br><br>Findings:<br><br>1. The policy/procedure Radiation Safety (revised 05-2005) failed to indicate a radiologist or radiation oncologist was required to supervise the provision of radiology services or otherwise performed a periodic review of radiologic policies, procedures and quarterly radiation dosimetry badge reports for the center.<br><br>2. On 07-26-2011 at 1200 hours, employee #A1 confirmed that he had reviewed and signed the Radiation Safety policy in 2005 and the facility was not utilizing a radiologist or radiation oncologist for a periodic review of the radiologic services. | S1210 | ffire in tthe ffiacilitty<br><br>1. Plan of Correction: An agreement with a radiologist will be signed for the oversight of radiology services provided. Exhibit(s)Radiologist agreement for oversight of radiology services 2. Prevention: The agreement will be monitored for renewal. The reports on oversight by the radiologist will be included in the MQIC meeting and summary presented to the Governing Body quarterly. 3. Responsible Person(s): Executive Assistant 4. Correction Completed: a. Radiology agreement was completed on July 26, 2011b. To presented to the governing body for approval. | 07/27/2011 |

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